

SSMC

Program: HAP Standard: PC.01.02.07 EP: 4

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Senior Vice President for Patient Care Services is responsible for the implementation and compliance of the pain reassessment.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

Changes were made to the electronic record on March 6th, 2013 to enable RNs to accurately document pain assessment and reassessment. Mandatory In-service education was provided immediately by Staff Development to all RN staff and continued on March 6th, 2013 through April 26th, 2013.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The sequence of pain reassessment criteria on the eMAR was corrected immediately during the survey. In-service education was provided by Staff Development immediately after the correction was completed and continued on March 6th through April 26th, 2013 through mandated education for all RNs.

**HOW:** A description of how the policy or process was implemented.

The Nursing Care Coordinator will perform a monthly medical record review to assess ongoing compliance with pain reassessment.

Close

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Program: HAP Standard: PC.01.02.07 EP: 4

**Evaluation Method:**

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Random systematic audits of medical records on the unit cited to determine compliance with pain reassessment will be done monthly for 4 consecutive months. 50 medical records per month will be audited. The denominator equals the number of records of patients receiving pain medication. The numerator equals the number of records in which the pain reassessment is documented. The audit results will be reported to the Hospital Quality Improvement Committee, to the Quality Care Committee and to the Board of Governors.

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Program: HAP Standard: PC.02.01.03 EP: 4

**Corrective Action Taken:**

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**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Senior Vice President Patient Services in collaboration with the Senior Vice President Medical Affairs is responsible for the corrective action and ongoing compliance with the giving and obtaining of orders from a licensed independent practitioner in accordance with Hospital policy.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The contracted RNs and the MDs were counseled immediately to cease and desist pre-signed order sheets and the routine use of telephone orders. Hospital policies were reviewed with all contracted staff and MDs. Disciplinary action taken involved the MDs who had pre-signed the order sheets and the contracted RNs who accepted the pre-signed orders. The contracted RNs were replaced and the new contracted RNs were educated on appropriate Hospital policies and procedures. Monitoring of MD orders started March 8, 2013. Electronic MD order set guidelines were approved and implemented. The Senior Vice President Operations sent to the contracted dialysis vendor a 30 day notice of termination of contract pending immediate corrective action and cure of deficiencies. Hospital and contracted vendor management and MD Directors met to establish additional QI indicators in the contract for measurement of compliance with the corrective action plan and the Hospital expectations of the contracted service staff and the MDs. The additional QI addendum to the contract was signed by the Hospital and contracted vendor March 27, 2013. A QI Team (Acute Dialysis QI Committee) with Hospital and contracted service representatives as well as the nephrology MDs was established to provide ongoing monitoring of compliance with an expanded QI dashboard which includes the MD order sheets.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The MDs and contracted RNs were counseled individually on March 7, 2013 to immediately stop the use of pre-signed orders and routine telephone orders. On March 14, 2013 a letter of discipline was put in the files of the contracted RNs and the MDs. The contracted RNs were replaced and the new contracted RNs were educated on appropriate Hospital policies and procedures on March 14, 2013. Monitoring measures auditing the MD orders/signatures were put in place March 8, 2013. On March 13, 2013 the Hospital Senior Vice President Medical Affairs met with the Dialysis Medical Director and Assistant Director to approve guidelines for handling electronic medical orders regarding dialysis, and on March 15, 2013 the revised policy was implemented by the nephrologists. On March 12 the Hospital management met with the contracted Dialysis management team to give 30 day notice of termination pending corrective action, as well as a list of corrective measures, an expanded QI dashboard of Hospital expectations, and a weekly schedule of meetings of the Acute Dialysis QI Committee to track the corrective action. The additional QI addendum to the contract was signed by the Hospital and contracted vendor March 27, 2013. The Acute Dialysis QI Committee has met weekly March 26, 2013 through April 30, 2013 and will meet monthly starting May 7, 2013 to monitor the corrective action implementation and the ongoing monitoring of the QI dashboard. The first Acute Dialysis QI Committee report was given to the Medical Board April 16, 2013, to the Medical Board May 1, 2013 and will go to Hospital QI Committee May 21, 2013.

**HOW:** A description of how the policy or process was implemented.

An expanded QI dashboard was created and incorporated into a contractual amendment with the contracted provider March 27, 2013. The Acute Dialysis QI Committee has met weekly March 26, 2013 through April 30, 2013. Effective May 7, 2013 the Acute Dialysis QI Committee will meet and report monthly to the Hospital QI Committee, Medical Board QI and to the Board of Governors. If 100%

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compliant for 6 months on all standards in the QI dashboard, the Acute QI Dialysis Committee will meet quarterly and report to the Hospital QI Committee, Medical Board QI and to the Board of Governors quarterly.

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May 20, 2013

John R. Spicer  
President and CEO  
Sound Shore Medical Center of Westchester  
16 Guion Place  
New Rochelle, NY 10802

Joint Commission ID #: 5807  
Program: Hospital Accreditation  
Accreditation Activity: 45-day Evidence of  
Standards Compliance  
Accreditation Activity Completed:  
05/16/2013

Dear Mr. Spicer:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark G. Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations



Sound Shore Medical Center of Westchester  
16 Guion Place  
New Rochelle, NY 10802

**Organization Identification Number: 5807**

**Evidence of Standards Compliance (45 Day) Submitted: 5/16/2013**

**Program(s)**  
Hospital Accreditation

**Executive Summary**

**Hospital Accreditation :** As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

**The Joint Commission  
Summary of Compliance**

<b>Program</b>	<b>Standard</b>	<b>Level of Compliance</b>
HAP	EC.02.04.03	Compliant
HAP	EC.02.05.01	Compliant
HAP	EC.02.05.07	Compliant
HAP	EM.02.02.13	Compliant
HAP	LS.02.01.34	Compliant
HAP	MM.03.01.01	Compliant
HAP	MM.05.01.07	Compliant
HAP	PC.01.02.07	Compliant
HAP	PC.02.01.03	Compliant

**The Joint Commission  
Summary of CMS Findings**

**CoP:** §482.23 **Tag:** A-0385 **Deficiency:** Compliant

**Corresponds to:** HAP

**Text:** §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)	A-0404	HAP - PC.02.01.03/EP1	Compliant

**CoP:** §482.25 **Tag:** A-0490 **Deficiency:** Compliant

**Corresponds to:** HAP

**Text:** §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(1)	A-0501	HAP - MM.05.01.07/EP1	Compliant

**CoP:** §482.41 **Tag:** A-0700 **Deficiency:** Compliant

**Corresponds to:** HAP

**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.05.07/EP4, EP6	Compliant
§482.41(b)(1)(I)	A-0710	HAP - LS.02.01.34/EP2, EP4	Compliant

**CoP:** §482.51 **Tag:** A-0940 **Deficiency:** Compliant

**Corresponds to:** HAP - EC.02.05.01/EP6

**Text:** §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

The Joint Commission

**Connect™ / ESC-MOS**

Evidence of Standards Compliance

Logged-In: Francine Cieslinski Extranet Home  
Sound Shore Medical Center of Westchester  
16 Gulton Place  
New Rochelle, NY 10802  
HGO ID:5807

## Event Summary

### Select Event

- Resource Documents
- How To Navigate
- Clarification Instructions
- ESC Instructions
- ESC FAQs

Please check this box to see the Ten Day Clarification Information.

### ESC Instructions

The Due Date for your ESC45 is 05/02/2013.

### ESC 45 Day

Address each standard indicated below. Once all the standards have been addressed click on the Submit ESC 45 button at the bottom of the page.

Manuals	Standard	Standard Text	Total EPs	Addressed 10-Day Clarif EPs	Addressed 45 Day EPs
HAP	EC.02.04.03	The hospital inspects, tests, and maintains medical equipment.	1	0	1
HAP	EC.02.05.01	The hospital manages risks associated with its utility systems.	1	0	1
HAP	EC.02.05.07	The hospital inspects, tests, and maintains emergency power systems. Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.	2	0	2
HAP	EM.02.02.13	During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners. Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.	1	0	1
HAP	LS.01.02.01	The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.	1	1	0
HAP	LS.02.01.34	The hospital provides and maintains fire alarm systems.	2	0	2
HAP	MM.03.01.01	The hospital safely stores medications.	1	0	1
HAP	MM.05.01.07	The hospital safely prepares medications.	1	0	1
HAP	PC.01.02.07	The hospital assesses and manages the patient's pain.	1	0	1
HAP	PC.02.01.03	The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.	1	0	1

The Due Date for your ESC60 is 05/17/2013.

### ESC 60 Day

Address each standard indicated below. Once all the standards have been addressed click on the Submit ESC 60 button at the bottom of the page.

Manuals	Standard	Standard Text	Total EPs	Addressed 10-Day Clarif EPs	Addressed 60 Day EPs
HAP	EC.02.03.03	The hospital conducts fire drills.	2	1	1 ✓
HAP	EC.02.03.05	The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	1	0	1 ✓
HAP	IC.02.02.01	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	1	0	1 ✓
HAP	LD.04.03.09	Care, treatment, and services provided through contractual agreement are provided safely and effectively.	3	1	2 ✓
HAP	LS.02.01.10	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.	1	0	1 ✓
HAP	LS.02.01.20	The hospital maintains the integrity of the means of egress.	2	0	2 ✓
HAP	LS.02.01.30	The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.	2	0	2 ✓
HAP	LS.02.01.35	The hospital provides and maintains systems for extinguishing fires.	1	0	1 ✓
HAP	MM.04.01.01	Medication orders are clear and accurate.	1	0	1 ✓
HAP	MS.06.01.03	The hospital collects information regarding each practitioner's	1	0	1 ✓

Joint Commission Connect - Central Office - Event Summary

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		current license status, training, experience, competence, and ability to perform the requested privilege.				
HAP	<u>MS.05.01.05</u>	The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.	1	0	1	✓
HAP	<u>MS.08.01.01</u>	The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.	1	0	1	✓
HAP	<u>RC.01.01.01</u>	The hospital maintains complete and accurate medical records for each individual patient.	1	0	1	✓

Submit ESC 45

Submit ESC 80

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Program: HAP Standard: EC.02.03.03 EP: 2

**Corrective Action Taken:**

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**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Fire Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

- On April 4, 2013 during Environmental Rounds, the staff at Cardiac Rehab was in-serviced on the Fire Drill Policy for Business Occupancies.
- Upon completion of the in-service, a Fire Drill was conducted.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

- In-service of the staff and the Fire Drill were both completed on April 4, 2013.

**HOW:** A description of how the policy or process was implemented.

- Monitoring of the staff knowledge of Fire Drills and Fire Safety will be conducted during the semi-annual Environmental Rounds for this space.

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Program: HAP Standard: EC.02.03.05 EP: 1

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Fire Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

1. Policy on Fire Equipment Inspections, Policy for Fire Pump Weekly Flow Test and the Weekly Fire Pump Test Log will be revised to require recording the suction & discharge pressure and run time of the test. 2. Additional training for staff responsible will be conducted to review the NFPA requirements of the test and to reivew the policy changes and log changes.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

1. Policy on Fire Equipment Inspections, Policy for Fire Pump Weekly Flow Test and the Weekly Fire Pump Test Log was revised on 3/25/13. 2. Training was conducted on the NFPA requirements for the weekly fire pump testing by S&S Sprinkler Company on 3/25/13. 3. Training was conducted for the revised Policy on Fire Equipment Inspections, Policy for Fire Pump Weekly Flow Test and the Weekly Fire Pump Test Log on 3/25/13.

**HOW:** A description of how the policy or process was implemented.

The Assistant Director of Plant Services will conduct weekly reviews of the Weekly Fire Pump Test log to ensure compliance.

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Program: HAP Standard: EC.02.03.05 EP: 1

**Evaluation Method:**

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Weekly monitoring of the fire pump log will be performed for four months.

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Program: HAP Standard: IC.02.02.01 EP: 1

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Senior Vice President for Patient Care Services is ultimately responsible for the corrective action and overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

Central Sterile policy and the OR policy have been revised. The process now includes placing laryngoscope blades and handles in sealed peel pouch bags after disinfection and prior to placing them in a clean Crash Cart/ Anesthesia Cart. The Crash Cart content list for the Adult and Pediatric patient has been revised to include Laryngoscope blades and handles are in a sealed peel pouch. The lists are completed by Central Sterile and are placed on top of the Crash Cart after all contents are placed in the cart. The Code Blue CQI tool was revised and now includes Laryngoscope blades and handles in a sealed peel pouch. During a Code Blue the observer will check and document on the tool that the laryngoscope blade(s) and the handle were in a sealed peel pouch when the Crash Cart was opened.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

All Crash Carts were checked and restocked with laryngoscopes blades and handles in sealed peel pouches by Central Sterile on April 5th, 2013. In the OR, the Anesthesia Tech, Operative Services tech and Nursing revised policy and are stocking laryngoscope blades and handles in sealed peel pouches as of April 13th, 2013. The Crash Cart content list for the Adult and Pediatric patient was revised April 5th, 2013. The Code Blue CQI tool was revised April 5th, 2013.

**HOW:** A description of how the policy or process was implemented.

Compliance will be sustained with this element of performance by the following actions: the Central Sterile staff will collect the Crash Cart content list when a cart is returned for an exchange. The content lists will be collected monthly to assure contents included Laryngoscope blades and handles in sealed peel pouches. All Code Blue CQI tools will be reviewed monthly to assure the Code Cart used contained Laryngoscope blades and handles in sealed peel pouches. If a cart contained a laryngoscope blade or handle not in a sealed peel pouch, the Manager of Central Sterile will review the Central Sterile Crash Cart log to identify the employee who restocked the cart. Re-education will be provided by the Central Sterile Manager.

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Program: HAP Standard: IC.02.02.01 EP: 1

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**Evaluation Method:**

(This display is not editable)

100% review of all Crash Cart content lists and Code Blue CQI tools will be done monthly for 4 months. Crash Cart content lists: Denominator = total number of Crash Cart lists reviewed. Numerator= total number of Crash Cart lists with laryngoscope blades and handles in a sealed peel pouch indicated. Code Blue CQI tool: Denominator = total number of Code Blue CQI tools reviewed. Numerator = total number of Code Blue CQI tools with laryngoscope blades and handles in a sealed peel pouch present when Code Cart was opened. These audit results will be reported monthly to the Director of QI for Patient Care Services. Reports will be submitted monthly to the Hospital QI committee.

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Program: HAP Standard: LD.04.03.09 EP: 6

**Corrective Action Taken:**

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**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Senior Vice President Operations in collaboration with the Senior Vice President Patient Care Services and the Senior Vice President Medical Services is responsible for the corrective action and for evaluating the ongoing compliance with the Hospitals expectations of the contracted service.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The contracted RNs and the MDs were counseled immediately to cease and desist pre-signed order sheets and the routine use of telephone orders. Hospital policies were reviewed with all contracted staff and MDs. Disciplinary action taken involved the MDs who had pre-signed the order sheets and the contracted RNs who accepted the pre-signed orders. The contracted RNs were replaced and the new contracted RNs were educated on appropriate Hospital policies and procedures. Monitoring of MD orders started March 8, 2013. Electronic MD order set guidelines were approved and implemented. The Senior Vice President Operations sent to the contracted dialysis vendor a 30 day notice of termination of contract requiring immediate corrective action and cure of deficiencies. Hospital and contracted vendor management and MD Directors met to establish additional QI indicators in the contract for measurement of compliance with the corrective action plan and the Hospital expectations of the contracted service staff and the MDs. The additional QI addendum to the contract was signed by the Hospital and contracted vendor March 27, 2013. A QI Team (Acute Dialysis QI Committee) with Hospital and contracted service representatives as well as nephrology MDs was established to provide ongoing monitoring of compliance with an expanded QI dashboard: MD order sheets, treatment flowsheets, dialysis reactions, transfusion reactions, medication errors and adverse events. The Preventive Maintenance Log, the Renal Log (patient name, date of service, nurse and MD providers, machine number), the Calibration Log and the water /dialysate analysis reports are also included in the QI monthly monitoring by the Acute Dialysis QI Committee. Weekly QI rounds in the acute dialysis unit by Hospital and contracted members of the Acute Dialysis QI Committee were established to monitor ongoing compliance related to cleanliness of the unit, labeling of multi-dose vials and solutions, dating of chlorine strips, condition of ceiling tiles and tubing.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The MDs and contracted RNs were counseled individually on March 7, 2013 to immediately stop the use of pre-signed orders and routine telephone orders and educated again on Hospital policies regarding MD orders. The contracted RNs were also counseled on proper labeling of solutions, multi-dose vials and dating of chlorine strips. On March 14, 2013 a letter of discipline was put in the files of the contracted RNs and the MDs. The contracted RNs were replaced and the new contracted RNs were educated on appropriate Hospital policies and procedures on March 14, 2013. Monitoring measures auditing the MD orders/signatures were put in place March 8, 2013. On March 13, 2013 the Hospital Senior Vice President Medical Affairs met with the Dialysis Medical Director and Assistant Director to approve new guidelines for handling electronic medical orders for dialysis, and on March 15, 2013 the nephrologists were educated and the protocol implemented. On March 12 the Hospital met with the contracted Dialysis management team to give 30 day notice of termination pending corrective action as well as, a list of corrective measures, an expanded QI dashboard of Hospital expectations and a weekly schedule of meetings (Acute Dialysis Committee) to track the corrective action. The QI addendum to the contract was signed March 27, 2013. The Acute Dialysis QI Committee has met weekly March 26, 2013 through May 14, 2013 and going forward will meet monthly to continue to monitor the corrective action implementation and the ongoing monitoring of the QI dashboard. The first Acute Dialysis QI Committee report was presented to Medical Board QI April 16, 2013 and to the Medical Board May 1, 2013.

**HOW:** A description of how the policy or process was implemented.

An expanded QI dashboard was created and incorporated into a contractual amendment with the contracted provider March 27, 2013. The Acute Dialysis QI Committee has met weekly March 26, 2013 through May 14, 2013. Going forward the Acute Dialysis QI Committee will report monthly to the Hospital QI Committee, Medical Board QI and to the Board of Governors for 6 months. If 100% compliant for 6 months on all standards in the QI dashboard, the Acute Dialysis QI Committee will meet quarterly and report to the Hospital QI Committee, Medical Board QI and to the Board of Governors quarterly.

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Program: HAP Standard: LD.04.03.09 EP: 7

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**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Senior Vice President Patient Services, in collaboration with the Senior Vice President Operations and Senior Vice President Medical Affairs, is responsible for the corrective action and for improving contracted services that do not meet expectations.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The contracted RNs and the MDs were counseled immediately to cease and desist pre-signed order sheets and the routine use of telephone orders. Hospital policies were reviewed with all contracted staff and MDs. Disciplinary action taken involved the MDs who had pre-signed the order sheets and the contracted RNs who accepted the pre-signed orders. The contracted RNs were replaced and the new contracted RNs were educated on appropriate Hospital policies and procedures. Monitoring of MD orders started March 8, 2013. Electronic MD order set guidelines were approved and implemented. The Senior Vice President Operations sent to the contracted vendor a 30 day notice of termination of contract requiring immediate corrective action and cure of deficiencies. Hospital and contracted vendor management and MD Directors met to establish additional QI indicators in the contract for measurement of compliance with the corrective action plan and the Hospital expectations of the contracted service staff and the MDs. The addendum to the contract was signed by the Hospital and contracted vendor March 27, 2013. A QI Team (Acute Dialysis QI Committee) with Hospital and contracted service representatives as well as the nephrology MDs was established to provide ongoing monitoring of compliance with an expanded QI dashboard: MD order sheets, treatment flowsheets, dialysis reactions, transfusion reactions, medication errors and adverse events. The Preventive Maintenance Log, the Renal Log (patient name, date of service, nurse and MD providers, machine number), the Calibration Log and the water /dialysate analysis reports are also included in the QI monthly monitoring by the Acute Dialysis QI Committee. Weekly QI rounds in the acute dialysis unit by Hospital and contracted members of the Acute Dialysis QI Committee was established to monitor ongoing compliance related to cleanliness of the unit, labeling of multi-dose vials and solutions, dating of chlorine strips, condition of ceiling tiles and tubing.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The MDs and contracted RNs were counseled individually on March 7, 2013 to immediately stop the use of pre-signed orders and routine telephone orders and educated again on Hospital policies regarding MD orders. The contracted RNs were also counseled on proper labeling of solutions multi-dose vials and dating of chlorine strips. On March 14, 2013 a letter of discipline was put in the files of the contracted RNs and the MDs. The contracted RNs were replaced and the new contracted RNs were educated on appropriate Hospital policies and procedures on March 14, 2013. Monitoring measures auditing the MD orders/signatures were put in place March 8, 2013. On March 13, 2013 the Hospital Senior Vice President Medical Affairs met with the Dialysis Medical Director and Assistant Director to approve new guidelines for handling electronic medical orders regarding dialysis, and on March 15, 2013 the nephrologists were educated and the protocol implemented. On March 12 the Hospital met with the contracted Dialysis management team to give 30 day notice of termination pending corrective action as well as, a list of corrective measures, an expanded QI dashboard of Hospital expectations and a weekly measures, an expanded QI dashboard of Hospital expectations and a weekly schedule of meetings (Acute Dialysis QI Committee) to track the corrective action. The QI addendum to the contract was signed March 27, 2013. The Acute Dialysis QI Committee has met weekly March 26, 2013 through May 14, 2013 and going forward will meet monthly to monitor the corrective action implementation and the ongoing monitoring of the QI dashboard. The first Acute Dialysis QI Committee report was presented to Medical Board QI April 16, 2013 and to the Medical Board May 1, 2013.

**HOW:** A description of how the policy or process was implemented.

An expanded QI dashboard was created and incorporated into a contractual amendment with the contracted provider March 27, 2013. The Acute Dialysis QI Committee has met weekly March 26, 2013 through May 14, 2013. Going forward the Acute Dialysis QI Committee will meet and report monthly to the Hospital QI Committee, Medical Board QI and to the Board of Governors for 6 months. If 100% compliant for 6 months on all standards in the QI dashboard, the Acute Dialysis QI Committee will meet quarterly and report to the Hospital QI Committee, Medical Board QI and to the Board of Governors quarterly.

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Close

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Program: HAP Standard: LS.02.01.10 EP: 7

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**Corrective Action Taken:**

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**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Life Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

- The penetrations in the Mechanical Door located at top of stairwell G was corrected during the survey on 3/6/13.
- The penetrations in the telecom Door located at top of stairwell G was corrected during the survey on 3/6/13.
- The missing labels on the fire doors leading into Stairwell G, 8th floor, and Stairwell A, 7th floor, will be replace using an outside company.
- An ILSM Assessment will be completed for this and appropriate action will be taken.
- An SOC PFI will be created to "clearly" identify these doors.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

- The 2 doors in Stairwell G, Mechanical Room & telecom room, were corrected on 3/6/13.
- The missing Labels on the fire doors for Stairwell G, 8th floor, and Stairwell A, 7th floor, will be replaced by 6/30/13.

**HOW:** A description of how the policy or process was implemented.

The Administrator of Support Services, or his designee, will assign engineering staff to perform monthly inspections of all Fire Doors for a period of 6 months. Providing there are no issues, inspections will go back to a quarterly inspection schedule. These inspections will be kept in an inspection log in the engineering office. Results of these inspection reports will be made to the EOC Committee quarterly.

Close Print

Program: **HAP** Standard: **LS.02.01.20** EP: **13**

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Life Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

- The linen cart in the corridor in the Endoscopy suite was removed during the survey on 3/6/13. • The row of chairs in the corridor across from the infusion room was removed during the survey on 3/6/13.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

- Linen cart and row of chairs in the corridors were removed during the survey on 3/6/13.

**HOW:** A description of how the policy or process was implemented.

- Storage of unauthorized items in egress corridors will be monitored during Environmental Rounds. Any deficiencies will be reported to the EOC Committee Quarterly and those departments will be required to go through re-education of the Life Safety requirements.

Close

Print

Program: HAP Standard: LS.02.01.20 EP: 29

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Life Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

- The signage issues for the 9th Floor landing Stairwell "A," 8th floor and 7th floor stairwell "D" landings were corrected during the survey on 3/6/13.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

- All of the signage issues were corrected during the survey on 3/5/13.

**HOW:** A description of how the policy or process was implemented.

- On March 18, 2013 a survey of all of the stairwell signage was conducted and there were no additional issues identified.

Close

Print

Program: HAP Standard: LS.02.01.30 EP: 2

SSMC  
body

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Life Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

- The latching issue on the Endoscopy Dirty Utility Door located was corrected during the survey on 3/6/13.
- The penetrations in the linen/trash chute room door located were corrected during the survey on 3/6/13.
- The latching issue on the smoke barrier doors leading into 5 Joyce, 5th floor, and 4 Joyce A, 4th floor, were corrected during the survey on 3/6/13.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

- All the doors issues cited were corrected during the survey on 3/6/13.

**HOW:** A description of how the policy or process was implemented.

The Administrator of Support Services, or his designee, will assign engineering staff to perform monthly inspections of all Fire Doors for a period of 6 months. Providing there are no major issues, inspections will go back to a quarterly inspection schedule. These inspections will be kept in an inspection log in the engineering office. Results of these inspection reports will be made to the EOC Committee quarterly.

Close Print

Program: HAP Standard: LS.02.01.30 EP: 23

SSMC  
6004

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Life Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

- The latching issue on the Endoscopy Dirty Utility Door located was corrected during the survey on 3/6/13.
- The penetrations in the linen/trash chute room door located were corrected during the survey on 3/6/13.
- The latching issue on the smoke barrier doors leading into 5 Joyce, 5th floor, and 4 Joyce A, 4th floor, were corrected during the survey on 3/6/13.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

- All the doors issues cited were corrected during the survey on 3/6/13.

**HOW:** A description of how the policy or process was implemented.

The Administrator of Support Services, or his designee, will assign engineering staff to perform monthly inspections of all Fire Doors for a period of 6 months. Providing there are no major issues, inspections will go back to a quarterly inspection schedule. These inspections will be kept in an inspection log in the engineering office. Results of these inspection reports will be made to the EOC Committee quarterly.

SSMC

Program: HAP Standard: LS.02.01.35 BP: 23

6084

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Life Safety Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
• A survey of 823 sprinklers was conducted and it was determined that 74 escutcheon plates were missing. • An outside sprinkler company, S&S Sprinkler, was brought in to determine the exact escutcheon plate sprinkler assembly part needed for each sprinkler. • All the escutcheon plates were placed on order. • When they are received, they will be installed. Installation will be combination of in-house staff and S&S Sprinkler Company. • An ILSM Assessment will be completed for this and appropriate action will be taken. • An SOC PFI will be created.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
• The survey was completed 3/25/13. • S&S Sprinkler Company was brought in on 4/8/13 and the material was ordered the same day. • All the escutcheon plates are scheduled to arrive by 5/24/13. • The missing escutcheon plates will all be installed by 6/28/13.

**HOW:** A description of how the policy or process was implemented.  
• Monitoring of the sprinklers will be conducted during Environmental Rounds. Any deficiencies will be documented and corrected. • Results of these inspection reports and follow-up corrective actions will be made to the EOC Committee quarterly.

Close

Print

Program: HAP Standard: MM.04.01.01 EP: 23

SSMC  
6004

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Director of Pharmacy is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
The Policy for Pediatric dosages was revised and implemented by the Pharmacy. All Pharmacy employees received an in-service on the revised policy on April 26th, 2013. The IT department has built into the computer system weight based dosing. The system is set up to automatically calculate the Pediatric medication dosage using the patient's weight in kilograms (kg) and will not allow an order to go above the 'Dose Cap'. The ordering physician will be able to see the 'Dose Cap', as well as, the calculation on the order form. If the physician changes the weight or dosage the calculation built into the system will not allow the order to exceed the 'Dose Cap'. If the 'Dose Cap' is exceeded by the calculation then the error message below will display. The physician can manually enter the dose if they choose to exceed the "Dose Cap". The change went into production on May 16th, 2013. The Medical Director informed the Pediatricians regarding the IT changes on May 16th, 2013.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
The Pediatric Dosage policy was revised April, 2013 All Pharmacy employees received an in-service on the revised policy on April 26th, 2013. The computerized ordering process to calculate pediatric medication dosage using patient's weight in kilograms (kg) went into production on May 16th, 2013.

**HOW:** A description of how the policy or process was implemented.  
Compliance will be sustained with this element of performance: No medication order will reach the electronic medication record unless verified by a Pharmacist. This is noted in the electronic medical record for each medication ordered once completed.

Close Print

Program: HAP Standard: MS.06.01.03 EP: 23

SSMC  
GODY

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Medical Director is ultimately responsible for the corrective action and for the overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
Bylaws were changed as per Bylaw regulations. As of May 1st, 2013, privileges of all new members and newly approved privileges for existing members of the Medical staff will require ongoing professional practice evaluation. If at any time, concerns are raised to a practitioner's current clinical competence, practice behavior and/or ability to perform his/her privileged, a period of focused evaluation may be indicated. Upon completion of the focused evaluation, significant findings shall be reported to the Medical Director through the Medical QI committee or the President of the Medical board through the Executive committee. The Medical Director through the Medical QI Committee or the Executive Committee shall evaluate the results and make recommendation. Recommendations may include, but are not limited to the following: there are training/current competence issues. In this case, the matter is referred to the credentials Committee for evaluation further evaluation as necessary, subsequent review following the completion of proctoring or training required by the Credentials Committee shall occur to re-evaluate the practitioner's ability to exercise the privileges in question on an independent basis. The Department Directors/or their designee will evaluate all members of their department on a continuous and ongoing professional practice evaluation basis using these areas of competence: 1. patient care, 2. Medical /Clinical knowledge 3. Practice-based learning and improvement 4. Interpersonal and communication skills 5. Professionalism 6. Systems-based practice. The data for continuous and ongoing professional practice evaluation of department members will be collected as part of the departments Quality Improvement activities. Sources of data will include but are not limited to 1. Medical record review 2. Length of stay patterns 3. Practitioner's use of consultants 4 review of operative and other clinical procedures performed and their outcomes 5. Direct Observation 6. Use of Diagnostic and Treatment Techniques.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
May 1st, 2013 Bylaws were changed as per Bylaw regulations. Privileges of all new members and newly approved privileges for existing members of the medical staff will require ongoing professional practice evaluation. The data collected will be collated and presented the Medical Staff Secretary for placement in the records of the respective physicians or allied staff every 6 months. Findings may trigger a focused professional practice review. The Department directors or there designee will evaluate those staff members who function in a major way in the hospital setting on a continuous and ongoing basis using Peer Review Process as outlined by the Joint Commission. He/she will base his/her decisions for reappointment to the Medical staff, Privileging and delineation of privileges using responses from peer physicians.

**HOW:** A description of how the policy or process was implemented.  
Each Department Director/ Division Chief will submit their department / division evaluations every six months to the office of the Medical Director for placement of the reports in the respective individual's files.

Close Print

Program: HAP Standard: MS.06.01.05 EP: 23

SSMC  
GORDY

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Medical Director is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
Bylaws were changed as per Bylaw regulations. As of May 1st, 2013, privileges of all new members and newly approved privileges for existing members of the Medical staff will require ongoing professional practice evaluation. If at any time, concerns are raised relative to a practitioner's current clinical competence, practice behavior and/or ability to perform his/her privileges, a period of focused evaluation may be indicated. The Department Directors/or their designee will evaluate all members of their department on a continuous and ongoing professional practice evaluation basis using these areas of competence: 1. patient care, 2. Medical /Clinical knowledge3. Practice-based learning and improvement4. Interpersonal and communication skills 5. Professionalism 6. Systems-based practice. The data for continuous and ongoing professional practice evaluation of department members will be collected as part of the departments Quality Improvement activities. Sources of data will include but are not limited to 1. Medical record review2. Length of stay patterns 3. Practitioner's use of consultants4 review of operative and other clinical procedures performed and their outcomes5. Direct Observation6. Use of Diagnostic and Treatment Techniques.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
May 1st, 2013 Bylaws were changed as per Bylaw regulations. Privileges of all new members and newly approved privileges for existing members of the medical staff will require ongoing professional practice evaluation. The data collected will be collated and presented the Medical Staff Secretary for placement in the records of the respective physicians or allied staff every 6 months. Findings may trigger a focused professional practice review. The Department directors or there designee will evaluate those staff members who function in a major way in the hospital setting on a continuous and ongoing basis using Peer Review Process as outlined by the Joint Commission. He/She will base His/her decisions for reappointment to the Medical staff, Privileging and delineation of privileges using responses from peer physicians.

**HOW:** A description of how the policy or process was implemented.  
Each Department Director/ Division Chief will submit their department / division evaluations every six months to the office of the medical director for placement of the reports in the respective individual charts.

Close Print

Program: HAP Standard: MS.08.01.01 EP: 23

SSMC  
CO 24

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Medical Director is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
Bylaws were changed as per Bylaw regulations. As of May 1st, 2013, privileges of all new members and newly approved privileges for existing members of the Medical staff will require ongoing professional practice evaluation. If at any time, concerns are raised relative to a practitioner's current clinical competence, practice behavior and/or ability to perform his/her privileges, a period of focused evolution may be indicated. The practice of members of the Medical and Affiliated Medical staff will be monitored on an ongoing basis, consistent with the policy regarding Peer Review/Ongoing Professional Practice Evaluation. Ongoing evaluation may identify patterns, outcomes, complications or other indicators associated with the practice of a specific individual which suggest the need for focused evaluation in accordance with this policy. Additionally, as of May 1st, 2013, privileges of all new members and newly approved privileges for existing members of the Medical staff will require focused evaluation. The Department Directors/or their designee will evaluate all members of their department on a continuous and on-going professional practice evaluation basis. She/he will base her/his decisions for reappointment to the Medical Staff, Privileging and the Delineation of Privileging using data collected as a part of the departmental and hospital Quality Improvement activities and by using peer recommendations evaluating the following areas of competence every six months: 1. Patient care, 2. Medical/Clinical Knowledge, 3. Practice – based learning and improvement, 4.interpersonal and communications skills, 5. Professionalism, 6. Systems-based practice. The data for continuous and ongoing professional practice evaluation of department members will be collected as part of the department's Quality Improvement activities. Sources of data will include, but are not limited to the following: 1. Medical record review, 2.length of stay patterns, 3. Practitioner's use of consultants, 4.review of operative and other clinical procedures performed and their outcomes, 5. Direct observation, 6. Use of Diagnostic and Treatment techniques, 7.Discussion with other care staff, 8. Information from other sources (National Practitioner Data bank and Joint commission). Organizations: NYS Department of Health, NYS – Office of the Professions (Education Department), Office of professional Medical conduct, Medical Liability Insurers and Patient Complaints (written or verbal). A focused evaluation may include, but is not limited to one or more of the following: 1. Comparison of the practitioner's inpatient and outpatient complications/outcomes related to his/her peers, 2. Retrospective or prospective chart review, 3. Monitoring of clinical practice patterns, 4.proctoring, 5. External Peer review, 6.simulation, 7. Discussion with other individuals involved in the care of the practitioner's patients relative to the substance of the focused review. External peer review will be solicited when the Medical QI Committee or the Executive Committee of the Medical Board determines that an internal review would not be fair and objective when for example, 1.the case(s) under review is/are not performed by any other member of the Medical Staff;(2) when there is concern regarding competition between the practitioner in question and other practitioners on the Medical staff who would be considered appropriate peers; or (3) other circumstances exist that could compromise the review. The period of focused review is time limited. The duration and type of monitoring required will be dependent upon the nature/severity of the situation under evaluation, the type of privilege(s) in question and the practitioner's overall activity level. The affected practitioner and his/her Chief/Associate Chief/Section Chief are informed of the duration of the review as well as the mechanisms that will be employed during the review. The initial review period may be extended at the discretion of the Credentials committee, the Medical QI committee or the Executive Committee of the Medical Board or its appropriate designee based upon the extent to which sufficient information to evaluate the practitioner's performance has been obtained, Similarly, the initial method of evaluation may be expanded or supplemented with other methods as needed during the initial and any subsequent review periods. Upon completion of the

focused evaluation, significant findings shall be reported to the Medical Director through the Medical QI Committee or the President of the Medical Board through the Executive Committee. The Medical Director through the Medical QI Committee or the Executive committee shall evaluate the results and make a recommendation.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed. May 1st, 2013 Bylaws were changed as per Bylaw regulations. Privileges of all new members and newly approved privileges for existing members of the medical staff will require ongoing professional practice evaluation. The data collected will be collated and presented the Medical Staff Secretary for placement in the records of the respective physicians or allied staff every 6 months. Findings may trigger a focused professional practice review. The Department directors or there designee will evaluate those staff members who function in a major way in the hospital setting on a continuous and ongoing basis using Peer Review Process as outlined by the Joint Commission. He/she will base his/her decisions for reappointment to the Medical staff, Privileging and delineation of privileges using responses from peer physicians.

**HOW:** A description of how the policy or process was implemented. Each Department Director/ Division Chief will submit their department / division evaluations every six months to the office of the Medical Director for placement of the reports in the respective individual's files.

SSMC

COPY

Program: HAP Standard: RC.01.01.01 EP: 23

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**Corrective Action Taken:**

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Assistant Vice President for Health Information Management is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
Record of Care Policy 01.01.01 was reviewed with the Chief of Gastroenterology and reinforced with members of the division of Gastroenterology specific to all medical record entries must be legible, complete, signed, dated and timed. Further a letter was sent to the Office Management Staff of this division restating Sound Shore Medical Center's policy relative to Record of Care 01.01.01. The Consent for Operation, Transfusion, Procedure or Treatment is being revised for ease of compliance with the Hospital Policy for authentication of all medical record entries.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
Review and reinforcement of the Hospital Policy with the Chief of the Division and members of his division was completed on March 22, 2013 by the Sr. Vice President of Medical Affairs. The letter was mailed to the Office Management Staff of this division on March 27, 2013 Expected date of the availability of the revised Informed Consent form is June, 2013

**HOW:** A description of how the policy or process was implemented.  
The Patient Access staff for the Gastroenterology Suite will monitor patient records for four (4) consecutive months. A minimum of 50 records will be selected each month; the selection of the records based upon first two cases per procedure room, per operational day, Monday thru Friday. Results of the audits will be shared monthly with the Chief of Gastroenterology and the Sr. Vice President of Medical Affairs and reported at the monthly Medical Staff Quality Improvement meetings. The Sr. Vice President for Medical Affairs will report results to the Board of Trustees of Sound Shore Medical Center. The Measure of Success (MOS) is ninety per cent (90%).

Close

Print



March 8, 2013

John Spicer  
Chief Executive Officer  
The Mount Vernon Hospital  
12 North Seventh Avenue  
Mount Vernon, NY 10550

Joint Commission ID #: 5804  
Program: Hospital Accreditation  
Accreditation Activity: Unannounced Full  
Event  
Accreditation Activity Completed:  
03/07/2013

Dear Mr. Spicer:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

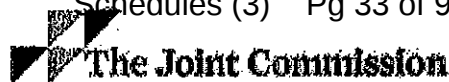
Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark G. Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations



The Mount Vernon Hospital  
12 North Seventh Avenue  
Mount Vernon, NY 10550

**Organization Identification Number: 5804**

**Program(s)**

Hospital Accreditation

Behavioral Health Care Accreditation

**Survey Date(s)**

03/05/2013-03/07/2013

**Executive Summary**

**Hospital Accreditation :** As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been Identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

**Behavioral Health Care Accreditation :** As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been Identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

**The Joint Commission  
Summary of Findings**

**Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	EC.02.05.01	EP6
	EM.02.02.13	EP4,EP5
	IC.02.02.01	EP2
	MM.03.01.01	EP7
	MM.05.01.07	EP2
	PC.01.03.01	EP1
<b>Program:</b>	Behavioral Health Care Accreditation Program	
<b>Standards:</b>	IM.02.02.01	EP3
	RC.02.01.01	EP2

**Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	EC.02.06.01	EP1
	HR.01.02.05	EP1
	LS.02.01.20	EP13,EP30,EP31
	MS.01.01.01	EP3,EP16
	MS.06.01.03	EP6
	MS.06.01.05	EP8
	RC.01.01.01	EP7
	RC.01.04.01	EP4
	TS.03.01.01	EP8
<b>Program:</b>	Behavioral Health Care Accreditation Program	
<b>Standards:</b>	HR.01.05.03	EP1
	LD.04.01.07	EP2
	RC.01.03.01	EP3

\* OCO - Observed Corrected Onsite.

**The Joint Commission**

**The Joint Commission  
Summary of CMS Findings**

**CoP:** §482.11 **Tag:** A-0020 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.11 Condition of Participation: Compliance with Federal, State and Local Laws

CoP Standard	Tag	Corresponds to	Deficiency
§482.11(c)	A-0023	HAP - MS.06.01.03/EP6	Standard

**CoP:** §482.22 **Tag:** A-0338 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(2)	A-0341	HAP - MS.06.01.05/EP8	Standard
§482.22(c)(5)(i)	A-0358	HAP - MS.01.01.01/EP16	Standard

**CoP:** §482.23 **Tag:** A-0385 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP1	Standard
§482.23(c)	A-0404	HAP - MM.05.01.07/EP2	Standard

**CoP:** §482.24 **Tag:** A-0431 **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)	A-0449	HAP - RC.01.01.01/EP7	Standard

**CoP:** §482.41 **Tag:** A-0700 **Deficiency:** Standard

**Corresponds to:** HAP

**The Joint Commission  
Summary of CMS Findings**

**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP13, EP30, EP31	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.06.01/EP1	Standard

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**CoP:** §482.42 **Tag:** A-0747 **Deficiency:** Standard

**Corresponds to:** HAP - IC.02.02.01/EP2,  
EC.02.05.01/EP6

**Text:** §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

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**CoP:** §482.51 **Tag:** A-0940 **Deficiency:** Standard

**Corresponds to:** HAP - IC.02.02.01/EP2

**Text:** §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

**The Joint Commission  
Findings**

**Chapter:** Emergency Management  
**Program:** Hospital Accreditation  
**Standard:** EM.02.02.13

REC-48 days

**Standard Text:** During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners.  
Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

**Primary Priority Focus Area:** Credentialed Practitioners

**Element(s) of Performance:**

4. The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review).



**Scoring**

**Category :** A  
**Score :** Insufficient Compliance

5. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:



- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster

**Scoring**

**Category :** A  
**Score :** Insufficient Compliance

**Observation(s):**

**The Joint Commission  
Findings**

**EP 4**

Observed in Document Review at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. The medical staff had not described, in writing, how it would oversee the performance of volunteer licensed independent practitioners who were granted disaster privileges.

**EP 5**

Observed in Document Review at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. The policy only required one form of identification rather than two, the policy and bylaws did not require one form of government issued photo identification and a second that identified the individual as a qualified healthcare provider.

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.05.01

ESC 48 days

**Standard Text:** The hospital manages risks associated with its utility systems.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

6. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies.



Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

**Scoring**

**Category :** A

**Score :** Insufficient Compliance

**Observation(s):**

**EP 6**

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control

This Standard is NOT MET as evidenced by:

Observed in Building Tour at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During tracer activity and a tour of the operating room area it was noted in the instrument clean room, used for surgical instrument packing and distribution, that the air pressure was negative relative to the outside hallway. Air pressure was also measured in operating room 1 and it was negative relative to the outside hallway.

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.06.01

ESC 40 days

**The Joint Commission  
Findings**

**Standard Text:**

The hospital establishes and maintains a safe, functional environment.  
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.



**Scoring**

**Category :**

C

**Score :**

Insufficient Compliance

**Observation(s):**

EP 1

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the unit it was noted that the medication cart was visibly soiled.

Observed in Individual Tracer at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the unit it was noted that the medication room counter was visibly soiled with dirt and dust particles in the corner.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the third floor unit it was noted that the oxygen cylinders were not separated and identified as full or empty.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

The ice machine in the dietary department deposited ice into a bin from which ice would be scooped. There was no cleaning schedule in place to insure the cleanliness of the equipment.

Observed in Building Tour at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the dietary kitchen, it was noted that there were 12 refrigerator temperature checks omissions in February and three omissions in January. The hospital's policy is to check the refrigerator temperatures twice daily.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the unit it was noted that the lift pad used to transfer patients was visibly soiled.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the unit it was noted that the base of the portable vital sign equipment, which was directly used by patients, was stained and soiled.

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**Chapter:**

Human Resources

**Program:**

Hospital Accreditation

**The Joint Commission  
Findings**

**Standard:** HR.01.02.05

ESC 60 days

**Standard Text:** The hospital verifies staff qualifications.

**Primary Priority Focus Area:** Credentialed Practitioners

**Element(s) of Performance:**

1. When law or regulation requires care providers to be currently licensed, certified, or registered to practice their professions, the hospital both verifies these credentials with the primary source and documents this verification when a provider is hired and when his or her credentials are renewed. (See also HR.01.02.07, EP 2)

Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.

Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.

Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.



**Scoring**

**Category :** A

**Score :** Insufficient Compliance

**Observation(s):**

EP 1

Observed In Competency Session at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site.

Review of a registered nurse's file indicated that the license expired in March 2012 and the primary source verification had been completed in May 2012, two months after renewal.

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**Chapter:** Infection Prevention and Control

**Program:** Hospital Accreditation

**Standard:** IC.02.02.01

ESC 45 days

**Standard Text:** The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

**Primary Priority Focus Area:** Infection Control

**The Joint Commission  
Findings**

**Element(s) of Performance:**

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. \* (See also EC.02.04.03, EP 4)



Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.

Footnote \*: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at

[http://www.cdc.gov/nicpac/Disinfection\\_Sterilization/acknowledg.html](http://www.cdc.gov/nicpac/Disinfection_Sterilization/acknowledg.html) (Sterilization and Disinfection in Healthcare Settings).

**Scoring**

**Category :**

A

**Score :**

Insufficient Compliance

**Observation(s):**

**EP 2**

§482.51 - (A-0940) - §482.51 Condition of Participation: Condition of Participation: Surgical Services

This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During tracer activity the logs of the bacterial indicators used for confirming sterilization were reviewed. The logs did not indicate the lot numbers of the controls or samples used in the growth of the biological indicators to compare with the lot numbers of the test and control samples. The log also did not indicate the results of the control samples.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During review of the endoscopy decontamination process it was noted that the test strips for Cidex OPA were not labeled with the opening dates or subsequent expiration dates related to the dates the strips were opened. Dating the strips is required to prevent the use of outdated strips for testing disinfecting solution strength. Staff also indicated that they did not perform QC testing of the test strips when the packages were opened as recommended by the manufacturer.

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control

This Condition is NOT MET as evidenced by:

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the radiology department it was noted that Cidex was utilized to disinfect probes. Review of the hospital's process indicated a lack of knowledge in regards to the manufacturer's instructions. The quality control test strips had expired in 2010 and the manufacturer's instructions for quality control had not been fully implemented to recognize the change in expiration dates after opening the container and the QC testing of the strips.

**Chapter:**

Life Safety

**Program:**

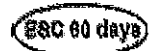
Hospital Accreditation

**Standard:**

LS.02.01.20

**Standard Text:**

The hospital maintains the integrity of the means of egress.



**The Joint Commission  
Findings**

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)



**Scoring**

**Category :**

C

**Score :**

Partial Compliance

30. Signs reading 'No Exit' are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text and any exceptions, refer to NFPA 101-2000: 7.10.8.1)



**Scoring**

**Category :**

A

**Score :**

Insufficient Compliance

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)



**Scoring**

**Category :**

C

**Score :**

Insufficient Compliance

**Observation(s):**

**The Joint Commission  
Findings**

**EP 13**

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During tracer activity it was noted that wheel chairs and gurneys were stored on one side of the hallway in the emergency department narrowing the hallway.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During a tour of the second floor unit, it was noted that there were multiple pieces of equipment stored in the corridor. This equipment included patient lifts, scales, medication carts, linen carts, computers and shelving that contained computers.

**EP 30**

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

Observed on the second floor in the Central Storage Supply area that there is two doors one in the rear and one near the front that lead into the Emergency Preparedness storage room that should have a NO EXIT sign attached because it is not an exit.

**EP 31**

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for

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Findings**

the Hospital deemed service.

Observed on the fourth floor in the O.R. Recovery area that there was no means of egress fixture to identify the exit door from the rear of the area.

Observed in Building Tour at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site for the Hospital deemed service.

Observed on the fourth floor in the O.R. Recovery area that there was no means of egress fixture to identify the exit door from the front of the area.

Observed in Building Tour at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

Observed on the second floor in the Central Storage Supply area that there is no means of egress fixture to identify the rear exit door from the area.

Observed in Building Tour at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site for the Hospital deemed service.

Observed on the second floor in the Central Storage Supply area that there is no means of egress fixture to identify the front exit door from the area.

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**Chapter:** Medical Staff  
**Program:** Hospital Accreditation  
**Standard:** MS.01.01.01

ESC 60 days

**Standard Text:** Medical staff bylaws address self-governance and accountability to the governing body.

**Primary Priority Focus Area:** Organizational Structure

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Findings**

**Element(s) of Performance:**

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.)

Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.



**Scoring**

**Category :**

A

**Score :**

Insufficient Compliance

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6 -11.)

Note 1: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.



**Scoring**

**Category :**

A

**Score :**

Insufficient Compliance

**Observation(s):**

**The Joint Commission  
Findings**

**EP 3**

Observed in Document Review at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. The organization had not amended the bylaws to include the basic steps for issues outlined in element of performance 16 as noted below.

**EP 16**

§482.22(c)(5)(i) - (A-0358) - (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

This Standard is NOT MET as evidenced by:

Observed in Document Review at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

The bylaws did not have information related to the completion of the history and physical that included information that the history and physical must be completed within 24 hours of admission or before surgery and that the update of history and physicals completed within the previous 30 days must be completed within the same time frame.

**Chapter:** Medical Staff  
**Program:** Hospital Accreditation  
**Standard:** MS.06.01.03

ESC 60 days

**Standard Text:** The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.

**Primary Priority Focus Area:** Credentialed Practitioners

**Element(s) of Performance:**

6. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information:

- The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration
- The applicant's relevant training
- The applicant's current competence

(See also PC.03.01.01, EP 1)



**Scoring**

**Category :** A  
**Score :** Insufficient Compliance

**Observation(s):**

**EP 6**

§482.11(c) - (A-0023) - (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

This Standard is NOT MET as evidenced by:

Observed in Medical Management Session at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During review of credential files it was noted that licensure had not been verified by primary source. There was documentation of primary source verification after the last survey when it was found that primary source verification had not occurred. Subsequent to this verification, at the time of the licensed independent practitioner's license renewal it was noted that the organization obtained a copy of the renewed license from the licensed independent practitioner applying for renewal of credentialing and privileges but primary source verification of the license did not take place.

**The Joint Commission  
Findings**

**Chapter:** Medical Staff  
**Program:** Hospital Accreditation  
**Standard:** MS.06.01.05

**ESC 60 days**

**Standard Text:** The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

**Primary Priority Focus Area:** Credentialed Practitioners

**Element(s) of Performance:**

8. Peer recommendation includes written information regarding the practitioner's current:

- Medical/clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.



**Scoring**

**Category :** A  
**Score :** Insufficient Compliance

**Observation(s):**

EP 8

§482.22(a)(2) - (A-0341) - (2) The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of these candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations, in addition to the requirements contained in this section. This Standard is NOT MET as evidenced by:

Observed in Medical Management Session at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During review of credential files for new and renewing applicants it was noted that for new applicants the peer recommendation did not include written information in all six areas as required. The peer letter was a request for a free text recommendation and there was no direction to the person providing the recommendation that would result in documenting information in all six required areas. For the records that were reviewed there was no information on communication or interpersonal skills.

**Chapter:** Medication Management  
**Program:** Hospital Accreditation  
**Standard:** MM.03.01.01

**ESC 45 days**

**Standard Text:** The hospital safely stores medications.

**Primary Priority Focus Area:** Medication Management

**The Joint Commission  
Findings**

**Element(s) of Performance:**

7. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.



**Scoring**

**Category :**

C

**Score :**

Insufficient Compliance

**Observation(s):**

EP 7

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. Medications were examined in the ICU. Opened insulin vials were stored in the refrigerators in the medication room and were labeled with the date the vial was opened and not with the expiration date.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. Medications were examined on the 2nd floor Med/Surg unit. Opened insulin vials were stored in the refrigerators in the medication room and were labeled with the date the vial was opened and not with the expiration date.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. Medications were examined in the Emergency Department. Opened insulin vials were stored in the refrigerators in the medication room and were labeled with the date the vial was opened and not with the expiration date.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. During a tour of the third floor medical surgical nursing unit it was noted that the various types of insulin vials were labeled with the date at the time of opening, not with the expiration date.

**Chapter:** Medication Management

**Program:** Hospital Accreditation

**Standard:** MM.05.01.07

ESC 45 days

**Standard Text:** The hospital safely prepares medications.

**Primary Priority Focus Area:** Medication Management

**Element(s) of Performance:**

2. Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.



**Scoring**

**Category :**

C

**Score :**

Insufficient Compliance

**Observation(s):**

**The Joint Commission  
Findings**

**EP 2**

**§482.23(c) - (A-0404) - §482.23(c) Standard: Preparation and Administration of Drugs**

(c) Standard: Preparation and administration of drugs. (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.

This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

The examination of the pill cutter used in the ICU revealed medication debris from previous use contaminating the cutter. A note on the cutter indicated that the pill cutter should be cleaned after use. The pill cutter could be used in its current unclean state thus contaminating medications for subsequent patient use.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

The examination of the pill cutter used on the 2nd floor Med/Surg unit revealed medication debris from previous use contaminating the cutter. A note on the cutter indicated that the pill cutter should be cleaned after use. The pill cutter could be used in its current unclean state thus contaminating medications for subsequent patient use.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

Discussion with the nurse indicated that some IV admixtures are prepared by the nurses on the unit. The nurse stated that she prepares the IVs on top of the medication cart without any special preparation of the area.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

Discussion with a second nurse indicated that some IV admixtures are prepared by the nurses on the unit. This nurse stated that the medication counter top was utilized and did not describe how the area would be prepared to maintain a clean uncluttered surface. At the time of the survey the area contained blood glucose equipment and was visibly soiled. Above the counter area was a sign which read "IV tray" however the nurse manager stated that they did not use an IV tray to prepare medications and she removed the sign. There was no process to provide a clean uncluttered functional area to prepare IV solutions.

**Chapter:** Provision of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** PC.01.03.01

EB0 45 days

**Standard Text:** The hospital plans the patient's care.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2)



**Scoring**

**Category :**

C

**Score :**

Insufficient Compliance

**Observation(s):**

**The Joint Commission  
Findings**

**EP 1**

§482.23(b)(4) - (A-0396) - (4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

The patient had been admitted to the unit with a MRSA positive culture. The plan of care did not address the necessary precautions.

Observed in Individual Tracer at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

The nursing assessment indicated that the patient only spoke French. The plan of care did not address the needs for communication or translation services for this patient.

Observed in Individual Tracer at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During review of the medical record, it was noted that the physician and nursing assessment identified that the patient was legally blind. The plan of care did not address the vision impairment with a goal or action to meet the patient's needs.

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**Chapter:** Record of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** RC.01.01.01

ESC 00 days

**Standard Text:** The hospital maintains complete and accurate medical records for each individual patient.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

7. The medical record contains information that documents the course and result of the patient's care, treatment, and services.



**Scoring**

**Category :** C

**Score :** Partial Compliance

**Observation(s):**

**The Joint Commission  
Findings**

EP 7

§482.24(c) - (A-0449) - §482.24(c) Standard: Content of Record

The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During review of the medical record it was noted that the patient was admitted to the hospital through the emergency room. The admission order had been written at 8:00 PM on February 27th. The first nurse's note on the unit was written at 8:00 AM on February 28th. According to hospital policy, Transfer of Patients on Nursing Units, "a brief narrative note is written by both the sending and the receiving nurse where patient was transferred from, where the patient was received, and how the patient was transported." It could not be determined, because of lack of documentation, when the patient had been transferred from the emergency room to the nursing unit.

Observed in Tracer Activities at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site for the Hospital deemed service.

During review of the medical record it was noted that the patient was admitted to the hospital through the emergency room. The admission order had been written at 2:30 PM on March 4th. The first nurse's note on the unit was written at 10:50 PM on March 4th. According to hospital policy, Transfer of Patients on Nursing Units, "a brief narrative note is written by both the sending and the receiving nurse where patient was transferred from, where the patient was received, and how the patient was transported." It could not be determined, because of lack of documentation, when the patient had been transferred from the emergency room to the nursing unit.

**Chapter:** Record of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** RC.01.04.01

ESC 60 days

**Standard Text:** The hospital audits its medical records.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

4. The medical record delinquency rate averaged from the last four quarterly measurements is 50% or less of the average monthly discharge (AMD) rate. Each individual quarterly measurement is no greater than 50% of the AMD rate. (See also MS.05.01.03, EP 3)  
Note: To calculate the quarterly and annual average medical record delinquency rate, the Medical Record Statistics Form can be used. This form is available at [http://www.jointcommission.org/Hospital\\_Medical\\_Record\\_Statistics\\_Form/](http://www.jointcommission.org/Hospital_Medical_Record_Statistics_Form/)



**Scoring**

**Category :** A

**Score :** Insufficient Compliance

**Observation(s):**

The quarterly delinquency rate exceeded 50% of the Average Monthly Discharge rate in three of four quarters reported as well as the total average rate for the year. The total average delinquency rate was 52% of the Average Monthly Discharge Rate.

**Chapter:** Transplant Safety

**The Joint Commission  
Findings**

**Program:** Hospital Accreditation

**Standard:** TS.03.01.01

ESC 60 days

**Standard Text:** The hospital uses standardized procedures for managing tissues.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

8. The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. (See also TS.03.02.01, EP 5)



Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage.

Note 2: Tissues requiring no greater control than 'ambient temperature' (defined as the temperature of the immediate environment) for storage would not require temperature monitoring.

**Scoring**

**Category :** C

**Score :** Partial Compliance

**Observation(s):**

EP 8

Observed in Document Review at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. The organization did not document the daily temperature on Saturdays and Sundays when the operating room was closed in the area where tissue requiring storage at room temperature was kept during the month of February.

Observed in Document Review at The Mount Vernon Hospital (12 North Seventh Avenue, Mount Vernon, NY) site. When the operating room was closed on weekends daily temperatures were not recorded in the area where tissue requiring storage at room temperature was kept

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**Chapter:** Human Resources

**Program:** Behavioral Health Care Accreditation

**Standard:** HR.01.05.03

ESC 60 days

**Standard Text:** Staff participate in education and training.

**Primary Priority Focus Area:** Orientation & Training

**Element(s) of Performance:**

1. Staff participate in education and training to maintain or increase their competency. Staff participation is documented.



**Scoring**

**Category :** C

**Score :** Partial Compliance

**Observation(s):**

**The Joint Commission  
Findings**

**EP 1**

Observed in HR File Review at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

The complete training record that documented one staff member's participation and completion of training for more than the past twelve months was not in either of the two HR files reviewed during the survey.

Observed in HR File Review at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

The training record of a second ACT staff member was not included in either of the two HR files that were reviewed during the survey. The training files were intact through 2008 and not intact after 2008. Documentation of required training was not verified.

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**Chapter:** Information Management  
**Program:** Behavioral Health Care Accreditation  
**Standard:** IM.02.02.01 ESC 48 days  
**Standard Text:** The organization effectively manages the collection of health information.  
**Primary Priority Focus Area:** Communication

**Element(s) of Performance:**

3. The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

**Scoring**

**Category :** C  
**Score :** Partial Compliance

**Observation(s):**

**EP 3**

Observed in Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.


QD was used repeatedly in reports and orders in one clinical record at ACT.

Observed in Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

QD was used repeatedly in reports, notes and orders in a second clinical record reviewed at ACT.

**The Joint Commission  
Findings**

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**Chapter:** Leadership  
**Program:** Behavioral Health Care Accreditation  
**Standard:** LD.04.01.07   
**Standard Text:** The organization has policies and procedures that guide and support care, treatment, or services.  
**Primary Priority Focus Area:** Organizational Structure  
**Element(s) of Performance:**

2. The organization manages the implementation of policies and procedures.



**Scoring**  
**Category :** C  
**Score :** Partial Compliance

**Observation(s):**

EP 2


Observed In Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

The policies and procedures that are related to the provision of the scope of care in ACT indicate the need to provide groups that address wellness, MICA and vocational planning. Interviews with staff indicated that no groups were provided to the ACT clients for more than the past twelve months due to the availability of staff.

Observed In Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

The policies and procedures that relate to the scope of treatment that is required for the provision of Assertive Community Treatment indicate the staffing requirements for the team and the clinical disciplines that are required to be represented as members of the ACT Team. Interviews with staff indicated that the team did not consistently have nursing, social work and a substance abuse counselor on the team. The client census ranged from 55 to 62 over the past 12 or more months and there were months when there were only two or three clinicians on the ACT Team to provide the scope of ACT services to the clients.

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**Chapter:** Record of Care, Treatment, and Services  
**Program:** Behavioral Health Care Accreditation  
**Standard:** RC.01.03.01   
**Standard Text:** Documentation in the clinical/case record is entered in a timely manner.  
**Primary Priority Focus Area:** Communication  
**Element(s) of Performance:**

3. The organization implements its policy requiring timely entry of information into the clinical/case record of the individual served.



**Scoring**  
**Category :** C  
**Score :** Partial Compliance

**Observation(s):**

**The Joint Commission  
Findings**

**EP 3**

Observed In Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

One client was readmitted to ACT 3/12/12 after having been discharged more than six months. Assessments required at the time of admission were not timely. The Safety Assessment was not conducted until 2/8/13. The Crises Intervention Assessment was not conducted until 1/11/13. A psychosocial assessment was not initiated or updated. The Patient Rights was not updated and was dated 2006 from the previous admission.

Observed In Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

Treatment plan reviews were not timely or were not conducted in three of three clinical records reviewed during tracer activities. The Initial Treatment Plan and the Treatment Plan due after thirty days of admission were timely but the six month reviews were not timely in all three records.

**Chapter:** Record of Care, Treatment, and Services

**Program:** Behavioral Health Care Accreditation

**Standard:** RC.02.01.01

ESG 46 days

**Standard Text:** The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.

**Primary Priority Focus Area:** Assessment and Care/Services

**Element(s) of Performance:**

2. The clinical/case record of the individual served contains the following clinical information:



- The reason(s) for admission for care, treatment, or services
- The initial diagnosis, diagnostic impression(s), or condition(s)
- Any findings of assessments and reassessments
- Any allergies to food
- Any allergies to medications
- Any conclusions or impressions drawn from the medical history and physical examination
- Any diagnoses or conditions established during the course of care, treatment, or services
- Any consultation reports
- Any observations relevant to care, treatment, or services
- The response to care, treatment, or services
- Any emergency care, treatment, or services provided prior to arrival
- Any progress notes
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, and route
- Any access site for medication, administration devices used, and rate of administration (for intravenous therapy)
- Any adverse drug reactions
- Treatment goals, plan of care, and revisions to the plan of care, treatment, or services
- Orders for diagnostic and therapeutic tests and procedures and their results

**Scoring**

**Category :** C

**Score :** Insufficient Compliance

**The Joint Commission  
Findings**

**Observation(s):**

EP 2

Observed in Data Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

The frequency of progress note documentation in the clinical record was not consistent with documentation policy requirements. The treatment plan reviews were not conducted every six months as required by policy. The treatment plan is supposed to be reviewed two times a year and it has only been reviewed one time a year for the past three years.

Observed in Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

The progress notes in a second clinical record were not written at the frequency required by policy. The treatment plan was not reviewed every six months as required by the policy. No treatment plan reviews were in the clinical record during 2012 and the last time the treatment plan was reviewed was 7/28/13.

Observed in Individual Tracer at Mount Vernon Hospital-Behavioral Health Program (3 South 6th Avenue, Mount Vernon, NY) site.

The documentation in a third clinical record reviewed during tracer activities did not contain the required number of progress notes. There were months during the past twelve months when there were no progress notes entered into the clinical record. Treatment plan reviews were not in the clinical record every six months as per policy.

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March 8, 2013

John Spicer  
Chief Executive Officer  
The Mount Vernon Hospital  
12 North Seventh Avenue  
Mount Vernon, NY 10550

Joint Commission ID #: 5804  
Program: Hospital Accreditation  
Accreditation Activity: Unannounced Full  
Event  
Accreditation Activity Completed:  
03/07/2013

Dear Mr. Spicer:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark G. Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

Program: HAP Standard: PC.01.03.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Director of Nursing is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The Hospital's policy on "Interdisciplinary Plan of Care" was reviewed with the nursing staff with emphasis on the need to address the precautionary measures needed for patients on isolation; the need for the Plan of Care to address how the communication and or translation needs of the patient will be met; and the need for the Plan of Care to address the goals and actions to be taken to meet the needs of the patient who is visually impaired.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
The Hospital policy review with the staff was completed on May 1, 2013.

**HOW:** A description of how the policy or process was implemented.  
The Nursing Supervisory staff will monitor inpatient charts weekly. Results will be reported monthly to Hospital QI and quarterly to BOT.

Close Print



MUH

Page 2 of 2

Program: HAP Standard: PC.01.03.01 EP: 2

**Evaluation Method:**

(This display is not editable)

Numerator will be the number of charts having appropriate Plans of Care in Place, Denominator will be the number of charts reviewed. Monitoring will commence with the acceptance of the plan and be done for 4 consecutive months. Results will be reported monthly to the the Hospital QI Committee and Quarterly to the Board of Trustees.

2

MUH

Program: HAP Standard: MM.05.01.07 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Pharmacy Supervisor is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A policy and procedure titled Pill Cutters was developed and implemented. Pill cutters will now be dispensed by pharmacy for individual patient use when indicated. Medication Safety Policy was reviewed with nursing staff to ensure maintenance of medication preparation work surfaces utilizing standard precautions and free of equipment and supplies unrelated to the preparation of a given medication. It was established with the nursing staff that in the event of the need to prepare IV admixtures, only the medication room is to be utilized; and must have a clean uncluttered work surface before IV admixture can begin. Environmental Services Manager met with his staff to review their responsibilities for the daily cleaning of medication room counters.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

Policy and Procedure was developed 3/25/13. Education of Pharmacy staff will be completed by 4/15. Policy review and education of the Nursing Staff will be completed by 5/1/13. Environmental Services Staff education was completed by 4/8/13

**HOW:** A description of how the policy or process was implemented.

Compliance will be sustained thru bi-weekly monitoring of the ICU and Med. Surg. units. Results will be reported monthly to Hospital QI and quarterly to the BOT. Monitoring will commence upon acceptance of this plan.

Close Print

3'

MUH

Program: HAP Standard: MM.05.01.07 EP: 2

**Evaluation Method:**

(This display is not editable)

Numerator will represent compliance to standard. Denominator will represent the number of reviews performed.

Close Print

41

MVH

Program: HAP Standard: MM.03.01.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Pharmacy Supervisor is responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A policy titled Multi-dose Insulin Vial Expiration Dating was developed and implemented 3/20/13. In addition the policy and procedure entitled Multiple Dose Vials and Treatment Solutions was reviewed and revised on 3/13. Pharmacy and Nursing staff were educated regarding the new and revised policies.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The Policy policy titled Multi-dose Insulin Vial Expiration Dating was developed and implemented 3/20/13. In addition the policy and procedure entitled Multiple Dose Vials and Treatment Solutions was reviewed and revised on 3/13. Pharmacy and Nursing staff were educated regarding the new and revised policies. Nursing Education on the new and revised policy will be completed by May 1, 2013. Pharmacy education will be completed by April 14, 2013.

**HOW:** A description of how the policy or process was implemented.

Bi-Weekly inspections will be performed on all inpatient units that utilize insulin. Denominator will reflect total number of insulin vials on the unit. The numerator will consist of the number compliant with the standard. Inspections will be conducted weekly and reported monthly to the Hospital QI committee and to the Board of Trustees quarterly. Monitoring will commence upon acceptance of this plan.

Close Print

51

MVH

Program: HAP Standard: MM.03.01.01 EP: 2

**Evaluation Method:**

(This display is not editable)

Bi-Weekly inspections will be performed on all inpatient units that utilize insulin. Denominator will reflect total number of insulin vials on the unit. The numerator will consist of the number compliant with the standard. Inspections will be conducted weekly and reported monthly to the Hospital QI committee and to the Board of Trustees quarterly. Monitoring will commence upon acceptance of this plan.

Close Print

61

MUH

Page 1 of 1

Program: HAP Standard: IC.02.02.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Director of Nursing is responsible for the corrective action and overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The Standards and Protocols for sterilization using the steam Autoclave was reviewed with the staff on 4/4/13. The existing log was updated to reflect the lot numbers of the controls or samples used to compare with the lot numbers of the test and the control samples as well as action taken for positive findings. The staff was re-educated to the need to document the results of the control samples. (4/4/13) The Endoscopy Decontamination process was reviewed with the staff on 4/4/13, with emphasis on the need to date the test strips for Cidex to include opening and expiration dates. In addition the staff was re-educated to perform QC testing of the test strips when the packages are open in accordance with manufacturing guidelines. During the survey in the Radiology department the Cidex control strips were replaced. The policy titled Protocols for Use and Handling of Cidex and the Gus Station and quality control logs were developed and implemented. Staff training was performed on these procedures March 20th.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The Standards and Protocols for Sterilization using the steam Autoclave was reviewed with the staff on 4/4/13. Re-education of documentation of the results of the sterilization process was reviewed with the staff on 4/4/13. Endoscopy Decontamination process was reviewed with the staff on 4/4/13. Education of the Radiology staff regarding the Protocols for the Use and Handling of Cidex and Gus station and quality control logs was done on March 20, 2013

**HOW:** A description of how the policy or process was implemented.

Compliance will be sustained in the OR by monthly monitoring of the logs by the Director of Nursing or her designee. Findings will be reported to the Monthly Hospital QI Committee and to the Board of Trustees Quarterly. Compliance will be sustained in the Radiology department with monthly monitoring of the Quality Control logs by the Administrator of Imaging Services.

Close Print

7

MOH

Page 1 of 1

Program: HAP Standard: EM.02.02.13 EP: 5

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Senior Vice President of Medical Affairs is responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A Policy and Procedure titled Credentialing of Licensed Independent Practitioners in a Disaster was developed. To be credentialed each licensed independent practitioner the hospital will obtain two forms of identification, one of which will be a valid government issued photo identification issued by a state or federal agency and the second which will identify the individual as a qualified health care provider.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The Policy and Procedure was developed and implemented on March 11. It was presented and reviewed with the Medical Board on March 14th and April 11th.

**HOW:** A description of how the policy or process was implemented.

The Senior Vice President of Medical Affairs or his designee will oversee the implementation of the Policy during any situation that requires the granting of emergency privileges during a disaster.

Close Edit

8

MUH

Page 1 of 1

Program: HAP Standard: EM.02.02.13 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Senior Vice President for Medical Affairs is responsible for the corrective action and overall ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A policy and procedure titled Credentialing of Licensed Independent Practitioners in a Disaster was developed and implemented. The Professional performance of the licensed independent practitioner will be monitored through direct observation by the Chairman of the Department or his/her designee.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
The policy and procedure was developed March 11, 2013. The policy and procedure was presented to the Medical Board on March 14th and April 11th.

**HOW:** A description of how the policy or process was implemented.  
The Senior Vice President or his designee will oversee the implementation of the Policy during any situation that requires the granting of emergency privileges during a disaster.

Close Print

9.

MU H

Program: HAP Standard: EC.02.05.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Utility Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

Slipping belts on the air handling units AC8 which serves the surgical suite were replaced at the time of survey. This immediately resolved the issue for OR #1 and the instrument clean room. An inspection log will be created to test of all areas of the surgical suite designed to control airborne contaminants for appropriate pressure relationships.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
All repair work for OR #1 and the instrument clean room was completed during the survey on 3/6/13.  
The policy was revised and presented and approved by the EOC Committee on 4/11/13.

**HOW:** A description of how the policy or process was implemented.  
The Administrator of Support Services, or his designee, will assign engineering staff to perform weekly inspections of all areas of the surgical suite designed to control airborne contaminants for appropriate pressure relationships for a period of 2 months. Providing there are no issues with the pressure relationship in any of the rooms, inspections will go back to the monthly inspection schedule. These inspections will be kept in an inspection log in the engineering office. Results of these inspection reports will be made to the EOC Committee quarterly.

Close Print

101

MOH

Page 1 of 1

Program: BHC Standard: IM.02.02.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Program Director for ACT will be responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
The policy on Prohibited Abbreviations was reviewed with all staff at a unit meeting.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
On March 11, 2013 a staff meeting was held to discuss and review the Joint Commission Findings related to the inappropriate use of abbreviations A follow up in-service was held on April 1, 2013

**HOW:** A description of how the policy or process was implemented.  
A random sample of 30 charts per month will be reviewed to ensure that there aren't any unacceptable abbreviations used. The Program Director will be responsible to implement the monitoring.

Close Print

MU H

Page 1 of 1

Program: BHC Standard: IM.02.02.01 EP: 2

**Evaluation Method:**

(This display is not editable)

A random sample of 30 charts will be selected and reviewed monthly. Charts will be monitored for four consecutive months. The numerator will represent the number of charts compliant with the standard. The denominator will represent the number of charts reviewed. Monitoring will commence with the acceptance of the plan and be done for 4 consecutive months. Results will be reported monthly to the the Hospital QI Committee and Quarterly to the Board of Trustees.

12

MOH

Page 1 of 2

Program: BHC Standard: RC.02.01.01 BP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Program Director of ACT will be responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The Treatment Plans and Progress notes will be written in accordance with the ACT Policy. To achieve this the policy and the findings of the Joint Commission were reviewed with the staff.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
On 3/11/13, following completion of the survey by the Joint Commission the findings were reviewed with the staff. An additional in-service was held on 4/1/13 to review the policy and procedure.

**HOW:** A description of how the policy or process was implemented.  
Monthly the Program Director will review 30 for evidence of compliance.

Close Edit

13

MUH.

Page 4 of 4

Program: BHC Standard: RC.02.01.01 BP: 2

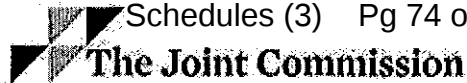
**Evaluation Method:**

(This display is not editable)

A random sample of 30 charts per month will be reviewed. The denominator will reflect the total number of charts reviewed. The numerator will reflect the number of charts compliant with the standard. Charts will be monitored for 4 consecutive month. Monitoring will commence upon acceptance of the plan. Results will be reported monthly to the Hospital QI committee and quarterly to the Board of Trustees.

Close Print

14



May 16, 2013

John Spicer  
Chief Executive Officer  
The Mount Vernon Hospital  
12 North Seventh Avenue  
Mount Vernon, NY 10550

Joint Commission ID #: 5804  
Program: Hospital Accreditation  
Accreditation Activity: 45-day Evidence of  
Standards Compliance  
Accreditation Activity Completed:  
05/16/2013

Dear Mr. Spicer:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark G. Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

MUH

Page 1 of 2

4504

Program: HAP Standard: PC.01.03.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Director of Nursing is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The Hospital's policy on "Interdisciplinary Plan of Care" was reviewed with the nursing staff with emphasis on the need to address the precautionary measures needed for patients on isolation; the need for the Plan of Care to address how the communication and or translation needs of the patient will be met; and the need for the Plan of Care to address the goals and actions to be taken to meet the needs of the patient who is visually impaired.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
The Hospital policy review with the staff was completed on May 1, 2013.

**HOW:** A description of how the policy or process was implemented.  
The Nursing Supervisory staff will monitor inpatient charts weekly. Results will be reported monthly to Hospital QI and quarterly to BOT.

1

MUH

Page 2 of 2

Program: HAP Standard: PC.01.03.01 EP: 2

**Evaluation Method:**

(This display is not editable)

Numerator will be the number of charts having appropriate Plans of Care in Place. Denominator will be the number of charts reviewed. Monitoring will commence with the acceptance of the plan and be done for 4 consecutive months. Results will be reported monthly to the the Hospital QI Committee and Quarterly to the Board of Trustees.

Close

Print

2

MU H

Program: HAP Standard: MM.05.01.07 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Pharmacy Supervisor is ultimately responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A policy and procedure titled Pill Cutters was developed and implemented. Pill cutters will now be dispensed by pharmacy for individual patient use when indicated. Medication Safety Policy was reviewed with nursing staff to ensure maintenance of medication preparation work surfaces utilizing standard precautions and free of equipment and supplies unrelated to the preparation of a given medication. It was established with the nursing staff that in the event of the need to prepare IV admixtures, only the medication room is to be utilized; and must have a clean uncluttered work surface before IV admixture can begin. Environmental Services Manager met with his staff to review their responsibilities for the daily cleaning of medication room counters.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

Policy and Procedure was developed 3/25/13. Education of Pharmacy staff will be completed by 4/15. Policy review and education of the Nursing Staff will be completed by 5/1/13. Environmental Services Staff education was completed by 4/8/13

**HOW:** A description of how the policy or process was implemented.

Compliance will be sustained thru bi-weekly monitoring of the ICU and Med. Surg.units Results will be reported monthly to Hospital QI and quarterly to the BOT.Monitoring will commence upon acceptance of this plan.

Close

Print

3'

MUH

Program: HAP Standard: MM.05.01.07 EP: 2

**Evaluation Method:**

(This display is not editable)

Numerator will represent compliance to standard. Denominator will represent the number of reviews performed.

Close

Print

41

MVH

Program: HAP Standard: MM.03.01.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Pharmacy Supervisor is responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A policy titled Multi-dose Insulin Vial Expiration Dating was developed and implemented 3/20/13. In addition the policy and procedure entitled Multiple Dose Vials and Treatment Solutions was reviewed and revised on 3/13. Pharmacy and Nursing staff were educated regarding the new and revised policies.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

The Policy policy titled Multi-dose Insulin Vial Expiration Dating was developed and implemented 3/20/13. In addition the policy and procedure entitled Multiple Dose Vials and Treatment Solutions was reviewed and revised on 3/13. Pharmacy and Nursing staff were educated regarding the new and revised policies. Nursing Education on the new and revised policy will be completed by May 1, 2013. Pharmacy education will be completed by April 14, 2013.

**HOW:** A description of how the policy or process was implemented.

Bi-Weekly inspections will be performed on all inpatient units that utilize insulin. Denominator will reflect total number of insulin vials on the unit. The numerator will consist of the number compliant with the standard. Inspections will be conducted weekly and reported monthly to the Hospital QI committee and to the Board of Trustees quarterly. Monitoring will commence upon acceptance of this plan.

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Program: HAP Standard: MM.03.01.01 EP: 2

**Evaluation Method:**

(This display is not editable)

Bi-Weekly inspections will be performed on all inpatient units that utilize insulin. Denominator will reflect total number of insulin vials on the unit. The numerator will consist of the number compliant with the standard. Inspections will be conducted weekly and reported monthly to the Hospital QI committee and to the Board of Trustees quarterly. Monitoring will commence upon acceptance of this plan.

Close

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MUH

Program: HAP Standard: IC.02.02.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Director of Nursing is responsible for the corrective action and overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The Standards and Protocols for sterilization using the steam Autoclave was reviewed with the staff on 4/4/13. The existing log was updated to reflect the lot numbers of the controls or samples used to compare with the lot numbers of the test and the control samples as well as action taken for positive findings. The staff was re-educated to the need to document the results of the control samples. (4/4/13) The Endoscopy Decontamination process was reviewed with the staff on 4/4/13, with emphasis on the need to date the test strips for Cidex to include opening and expiration dates. In addition the staff was re-educated to perform QC testing of the test strips when the packages are open in accordance with manufacturing guidelines. During the survey in the Radiology department the Cidex control strips were replaced. The policy titled Protocols for Use and Handling of Cidex and the Gus Station and quality control logs were developed and implemented. Staff training was performed on these procedures March 20th.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
The Standards and Protocols for Sterilization using the steam Autoclave was reviewed with the staff on 4/4/13. Re-education of documentation of the results of the sterilization process was reviewed with the staff on 4/4/13. Endoscopy Decontamination process was reviewed with the staff on 4/4/13. Education of the Radiology staff regarding the Protocols for the Use and Handling of Cidex and Gus station and quality control logs was done on March 20, 2013

**HOW:** A description of how the policy or process was implemented.  
Compliance will be sustained in the OR by monthly monitoring of the logs by the Director of Nursing or her designee. Findings will be reported to the Monthly Hospital QI Committee and to the Board of Trustees Quarterly. Compliance will be sustained in the Radiology department with monthly monitoring of the Quality Control logs by the Administrator of Imaging Services.

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MUH

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Program: HAP Standard: EM.02.02.13 EP: 5

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Senior Vice President of Medical Affairs is responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A Policy and Procedure titled Credentialing of Licensed Independent Practitioners in a Disaster was developed. To be credentialed each licensed independent practitioner the hospital will obtain two forms of identification, one of which will be a valid government issued photo identification issued by a state or federal agency and the second which will identify the individual as a qualified health care provider.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
The Policy and Procedure was developed and implemented on March 11. It was presented and reviewed with the Medical Board on March 14th and April 11th.

**HOW:** A description of how the policy or process was implemented.  
The Senior Vice President of Medical Affairs or his designee will oversee the implementation of the Policy during any situation that requires the granting of emergency privileges during a disaster.

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Page 1 of 1

Program: HAP Standard: EM.02.02.13 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Senior Vice President for Medical Affairs is responsible for the corrective action and overall ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

A policy and procedure titled Credentialing of Licensed Independent Practitioners in a Disaster was developed and implemented. The Professional performance of the licensed independent practitioner will be monitored through direct observation by the Chairman of the Department or his/her designee.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
The policy and procedure was developed March 11, 2013. The policy and procedure was presented to the Medical Board on March 14th and April 11th.

**HOW:** A description of how the policy or process was implemented.  
The Senior Vice President or his designee will oversee the implementation of the Policy during any situation that requires the granting of emergency privileges during a disaster.

9.

MU H

Program: HAP Standard: EC.02.05.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Administrator of Support Services is responsible for the corrective action, implementation and compliance of the Utility Policies.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

Slipping belts on the air handling units AC8 which serves the surgical suite were replaced at the time of survey. This immediately resolved the issue for OR #1 and the instrument clean room. An inspection log will be created to test of all areas of the surgical suite designed to control airborne contaminants for appropriate pressure relationships.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

All repair work for OR #1 and the instrument clean room was completed during the survey on 3/6/13.

The policy was revised and presented and approved by the EOC Committee on 4/11/13.

**HOW:** A description of how the policy or process was implemented.

The Administrator of Support Services, or his designee, will assign engineering staff to perform weekly inspections of all areas of the surgical suite designed to control airborne contaminants for appropriate pressure relationships for a period of 2 months. Providing there are no issues with the pressure relationship in any of the rooms, inspections will go back to the monthly inspection schedule. These inspections will be kept in an inspection log in the engineering office. Results of these inspection reports will be made to the EOC Committee quarterly.

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MOH

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Program: BHC Standard: IM.02.02.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Program Director for ACT will be responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

The policy on Prohibited Abbreviations was reviewed with all staff at a unit meeting.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
On March 11, 2013 a staff meeting was held to discuss and review the Joint Commission Findings related to the inappropriate use of abbreviations A follow up in-service was held on April 1, 2013

**HOW:** A description of how the policy or process was implemented.  
A random sample of 30 charts per month will be reviewed to ensure that there aren't any unacceptable abbreviations used. The Program Director will be responsible to implement the monitoring.

MU H

Page 7 of 7

Program: BHC Standard: IM.02.02.01 EP: 2

**Evaluation Method:**

(This display is not editable)

A random sample of 30 charts will be selected and reviewed monthly. Charts will be monitored for four consecutive months. The numerator will represent the number of charts compliant with the standard. The denominator will represent the number of charts reviewed. Monitoring will commence with the acceptance of the plan and be done for 4 consecutive months. Results will be reported monthly to the the Hospital QI Committee and Quarterly to the Board of Trustees.

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MO H

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2

Program: BHC Standard: RC.02.01.01 EP: 2

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.  
The Program Director of ACT will be responsible for the corrective action and for overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.  
The Treatment Plans and Progress notes will be written in accordance with the ACT Policy. To achieve this the policy and the findings of the Joint Commission were reviewed with the staff.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.  
On 3/11/13, following completion of the survey by the Joint Commission the findings were reviewed with the staff. An additional in-service was held on 4/1/13 to review the policy and procedure.

**HOW:** A description of how the policy or process was implemented.  
Monthly the Program Director will review 30 for evidence of compliance.

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MUH.

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Program: BHC Standard: RC.02.01.01 EP: 2

**Evaluation Method:**

(This display is not editable)

A random sample of 30 charts per month will be reviewed. The denominator will reflect the total number of charts reviewed. The numerator will reflect the number of charts compliant with the standard. Charts will be monitored for 4 consecutive month. Monitoring will commence upon acceptance of the plan. Results will be reported monthly to the Hospital QI committee and quarterly to the Board of Trustees.

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The Joint Commission

**Connect™ / ESC-MOS**

Evidence of Standards Compliance

Logged-in, Francine Cieslinski Extranet Home  
 The Mount Vernon Hospital  
 12 North Seventh Avenue  
 Mount Vernon, NY 10550  
 HCO ID:5804

## Event Summary

Select Event

Resource Documents

- How To Navigate
- Clarification Instructions
- ESC Instructions
- ESC FAQs

Please check this box to see the Ten Day Clarification Information.

ESC Instructions

The Due Date for your ESC45 is 05/07/2013.

ESC 45 Day

Address each standard indicated below. Once all the standards have been addressed click on the Submit ESC 45 button at the bottom of the page.

Manuals	Standard	Standard Text	Total EPs	Addressed 45 Day EPs
BHC	IM.02.02.01	The organization effectively manages the collection of health information.	1	1
BHC	RC.02.01.01	The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.	1	1
HAP	EC.02.05.01	The hospital manages risks associated with its utility systems.	1	1
HAP	EM.02.02.13	During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners. Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.	2	2
HAP	IC.02.02.01	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	1	1
HAP	MM.03.01.01	The hospital safely stores medications.	1	1
HAP	MM.05.01.07	The hospital safely prepares medications.	1	1
HAP	PC.01.03.01	The hospital plans the patient's care.	1	1

The Due Date for your ESC60 is 05/22/2013.

ESC 60 Day

Address each standard indicated below. Once all the standards have been addressed click on the Submit ESC 60 button at the bottom of the page.

Manuals	Standard	Standard Text	Total EPs	Addressed 60 Day EPs
BHC	HR.01.05.03	Staff participate in education and training.	1	1
BHC	LD.04.01.07	The organization has policies and procedures that guide and support care, treatment, or services.	1	1
BHC	RC.01.03.01	Documentation in the clinical/case record is entered in a timely manner.	1	1
HAP	EC.02.06.01	The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.	1	1
HAP	HR.01.02.05	The hospital verifies staff qualifications.	1	1
HAP	LS.02.01.20	The hospital maintains the integrity of the means of egress.	3	3
HAP	MS.01.01.01	Medical staff bylaws address self-governance and accountability to the governing body.	2	2
HAP	MS.06.01.03	The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.	1	1
HAP	MS.06.01.05	The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.	1	1
HAP	RC.01.01.01	The hospital maintains complete and accurate medical records for each individual patient.	1	1
HAP	RC.01.04.01	The hospital audits its medical records.	1	1
HAP	TS.03.01.01	The hospital uses standardized procedures for managing tissues.	1	1

Submit ESC 45

Submit ESC 60

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Program: BHC Standard: HR.01.05.03 EP: 1

**Corrective Action Taken:**

(This display is not editable)

**WHO:** Title of who is responsible for the corrective action and ongoing compliance. Title of who approved the action, policy, or procedure. Title of who was trained.

The Program Director for ACT will be responsible for the corrective action and for the overall and ongoing compliance.

**WHAT:** A description of the action taken, of the policy or process and how the element of performance was addressed.

Staff will attend relevant education and training to maintain and increase their competency. Staff participation will be documented. A documentation tool will be developed and implemented by May 17, 2013.

**WHEN:** A date of when each action, policy, procedure, and/or training was completed.

On 3/11/2013 a staff meeting was held and the findings of the Joint Commission Survey were reviewed with the staff. The importance of attending and documenting educational sessions were reviewed.

**HOW:** A description of how the policy or process was implemented.

Educational programs will be provided monthly. Staff participation will be documented by the Program Director or his designee.

Close

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